Lessons learned in developing community mental health care in Europe

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This paper summarizes the findings for the European Region of the WPA Task Force on Steps, Obstacles and Mistakes to Avoid in the Implementation of Community Mental Health Care. The article presents a description of the region, an overview of mental health policies and legislation, a summary of relevant research in the region, a precis of community mental health services, a discussion of the key lessons learned, and some recommendations for the future.

Key words: Community mental health care, Europe, mental health in primary care, legislation and policies, research, human rights, treatment gap, human resources

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This paper is part of a series which describes the development of community mental health care in regions around the world (see 1). It is one of the products of the Task Force appointed by the WPA, as part of its Action Plan 2008-2011 (2,3), to produce a Guidance on Steps, Obstacles and Mistakes to Avoid in the Implementation of Community Mental Health Care. The purpose, methods and main findings of this Task Force have been previously published in this journal (4). In this article, we describe these issues in relation to the World Health Organization (WHO) European region.

The WHO European Region consists of 53 countries and over 886 million people (5). It includes the former EU-15 countries (the fifteen countries that have been part of the European Union (EU) since before 2004), the 12 countries that joined the EU from 2004 onwards, the 11 countries of the Commonwealth of Independent States (CIS) (which incorporates most of the former Soviet Union's member states), eight countries from South-Eastern Europe, and seven non-EU high income countries (see Table 1). Generally speaking, there is an economic divide across Europe, with most of the high income countries (n=30) amongst EU (especially EU-15) countries and other primarily Western countries, all of the low income (n=3) and lower-middle income countries (n=7) in the non-EU Eastern parts of the region (most of which are CIS countries), and many of the upper-middle income countries (n=13) in the post-2004 EU countries and South-Eastern Europe (6).

Mental health problems are common and have a huge economic and social impact across Europe, with at least 25% of people in the region experiencing a mental disorder over their lifetime (7). In 2004, neuropsychiatric disorders accounted for 19.1% of all disability-adjusted life-years (DALYs), and 39% of all first-ranked cause of years lived with disability (YLD) (8). Unipolar depression alone was the third leading cause of DALYs (after ischaemic heart disease and cerebrovascular disease), accounting for 5.6% of DALYs in the region (9). Suicide rates are also high across the region, with a prevalence rate of 14.01 per 100,000 population in 2007 (5), and contributing 2% of total DALYs and 1.6% of all deaths in 2004 (8).

MENTAL HEALTH POLICIES AND LEGISLATION

Following various mental health treaties, action programmes and plans within the EU throughout the 1990s and early 2000s (9), a significant milestone in the development and reform of mental health policies across Europe was the Mental Health Declaration for Europe (10) and the Mental Health Action Plan for Europe (11) in 2005. Here all European health ministers acknowledged mental health as a priority area, recognized the need for evidence-based mental health policies, defined a broad scope for these policies, committed themselves to the development, implementation and reinforcement of such policies, and proposed twelve action areas and milestones to be implemented by 2010. This included a commitment to develop community-based mental health services, to downgrade large mental institutions, and to integrate mental health services into primary health care.

Most countries in Europe (around 83%) now have a mental health policy in place (see Table 1), with around 89% of the population in the region covered by 2005 (13). Similarly, almost all countries (over 95%) now have mental health legislation in place (see Table 1), with around 90% of the population covered by 2005 (13). Specific policies, strategies or plans for the development of community mental health services, as well as for the downgrading of large mental hospitals, and an integration of mental health into primary care, have now been developed in at least two thirds of European countries (see Table 1).

However, there are still large differences in policies between countries, and whilst in many countries policies have been updated in recent years to fit in with changing ideals of mental health service provision (with around half of the countries with mental health policies in place having either adopted new, or updated existing, policies since 2005), oth-

Table 1 Overview of mental health legislation, policies, services and psychiatrists in the European Region

	Mental health legislation and policies					Mental health in primary health care				Inpatient mental health services				
	Year of most recently approved or updated mental health legislation	Year of most recent mental health policy	Policies, strategies or plans: development of community mental health services	Policies, strategies or plans: downsizing of large mental hospitals	Policies, strategies or plans: mental health in primary care	Identification and referral to specialist services for common mental disorders in primary care	Diagnosis and/or treatment for common mental disorders in primary care	Identification and referral to specialist services for severe mental disorders in primary care	Diagnosis and/or treatment for severe mental disorders in primary care	Mental hospitals (inpatient services)	Community psychiatric inpatient units/ units in district general hospitals	Number of psychiatric public hospital beds per 100,000 population	Percentage of psychiatric beds in facilities other than mental hospitals (approximate)	Number of psychiatrists per 100,000 population
Former EU-15														
Austria	after 2005	after 2005	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	52	29%	13
Belgium	after 2005	after 2005	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	152	42%	23
Denmark	after 2005	after 2005	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	61	N/A	11
Finland	after 2005	1999-2004	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	Yes	72	99%	26
France	after 2005	after 2005	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	95	42%	22
Germany	after 2005	after 2005	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	75	40%	8.7
Greece	1999	1999-2004	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	18	22%	15
Ireland	after 2005	after 2005	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	94	24%	7.3
Italy	1978	after 2005	Yes	N/A	Yes	Yes	Yes	Yes	No	No	Yes	8	100%	9.8
Luxembourg	2000	1999-2004	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	97	46%	12
Netherlands	1999-2004	1999	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	114	18%	14.5
Portugal	1999-2004	after 2005	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	27	37%	6.7
Spain	after 2005	after 2005	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	47	16%	6.1
Sweden	2000	before 1998	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	54	93%	24
UK	after 2005	after 2005	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	23	39%	11
Other EU														
Bulgaria	after 2005	after 2005	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	64	56%	8.7
Cyprus	1999-2004	after 2005	Yes	Yes	Yes	N/A	N/A	N/A	Yes	Yes	Yes	27	22%	6.5
Czech Republic	after 2005	1999-2004	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	110	13%	13.7
Estonia	after 2005	No policy	No	No	No	Yes	Yes	Yes	Yes	Yes	Yes	56	22%	13
Hungary	1997	1999-2004	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	93	76%	13.7
Latvia	after 2005	2004	Yes	No	No	Yes	Yes	Yes	No	Yes	Yes	148	7%	11.3
Lithuania	after 2005	after 2005	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	88	11%	18
Malta	1981	1994	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	185	under 1%	4
Poland	after 2005	after 2005	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	65	25%	5.5
Romania	2002	after 2005	Yes	No	Yes	Yes	Yes	Yes	No	Yes	Yes	75	28%	4.7
Slovakia	after 2005	1999-2004	Yes	Yes	Yes	Yes	Yes	N/A	Yes	Yes	Yes	96	81%	9
Slovenia	before 1998	1999-2004	No	No	Yes	N/A	Yes	Yes	Yes	Yes	Yes	85	15%	5.4
South-Eastern														
Albania	1996	2003	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	24	25%	3
Bosnia and Herzegovina	2000	after 2005	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	36	33%	1.8
Croatia	1999-2004	after 2005	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	93	20%	8
Georgia	after 2005	No policy	No	No	No	Yes	No	Yes	No	Yes	No	29	0%	5.6
Montenegro	after 2005	1999-2004	Yes	No	Yes	Yes	Yes	Yes	Yes	Yes	No	49	0%	6.4
Serbia	Has legislation	after 2005	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	95	N/A	12
T.F.Y.R. of Macedonia	after 2005	after 2005	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	74	14%	9.5
Turkey	1999-2004	after 2005	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	12	25%	1

N/A: information not available

Data are taken from World Health Organization's publications (5,12-16). Where data were conflicting between publications, the most recent source was used

Table 1 Overview of mental health legislation, policies, services and psychiatrists in the European Region *(continued)*

	Mental health legislation and policies					Mental health in primary health care				Inpatient mental health services				
	Year of most recently approved or updated mental health legislation	Year of most recent mental health policy	Policies, strategies or plans: development of community mental health services	Policies, strategies or plans: downsizing of large mental hospitals	Policies, strategies or plans: mental health in primary care	Identification and referral to specialist services for common mental disorders in primary care	Diagnosis and/or treatment for common mental disorders in primary care	Identification and referral to specialist services for severe mental disorders in primary care	Diagnosis and/or treatment for severe mental disorders in primary care	Mental hospitals (inpatient services)	Community psychiatric inpatient units/ units in district general hospitals	Number of psychiatric public hospital beds per 100,000 population	Percentage of psychiatric beds in facilities other than mental hospitals (approximate)	Number of psychiatrists per 100,000 population
CIS														
Armenia	2004	1994	N/A	N/A	N/A	N/A	N/A	N/A	No	Yes	Yes	45	under 1%	5.8
Azerbaijan	2001	No policy	No	No	No	Yes	No	Yes	No	Yes	No	48	0%	5
Belarus	1999	No policy	N/A	N/A	N/A	N/A	N/A	N/A	Yes	Yes	Yes	70	6%	10.1
Kazakhstan	1997	1997	N/A	N/A	N/A	N/A	N/A	N/A	No	Yes	Yes	63	9%	6
Kyrgyzstan	1999	2000	N/A	N/A	N/A	N/A	N/A	N/A	No	Yes	Yes	43	10%	3.4
R. of Moldova	1998	No policy	Yes	No	Yes	Yes	Yes	Yes	No	Yes	No	63	0%	6
Russian Federation	1999-2004	after 2005	Yes	Yes	Yes	Yes	Yes	Yes	No	Yes	Yes	112	12%	10.9
Tajikistan	N/A	No policy	N/A	N/A	N/A	N/A	N/A	N/A	No	Yes	N/A	25	N/A	1.8
Turkmenistan	1993	1995	N/A	N/A	N/A	N/A	N/A	N/A	No	Yes	Yes	33	9%	3
Ukraine	2000	1988	N/A	N/A	N/A	N/A	N/A	N/A	No	Yes	Yes	94	3%	8.9
Uzbekistan	2000	1999-2004	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	32	3%	4
Other														
Andorra	No legislation	No policy	N/A	N/A	N/A	N/A	N/A	N/A	Yes	No	Yes	15	100%	10
Iceland	1997	No policy	N/A	N/A	N/A	N/A	N/A	N/A	Yes	No	Yes	50	100%	25
Israel	2000	after 2005	Yes	Yes	Yes	Yes	Yes	No	No	Yes	Yes	59	7%	8.8
Monaco	1981	Has policy	N/A	N/A	N/A	N/A	N/A	N/A	Yes	No	Yes	173	100%	28.5
Norway	after 2005	after 2005	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	119	42%	16
San Marino	Has legislation	No policy	N/A	N/A	N/A	N/A	N/A	N/A	Yes	No	Yes	38	100%	15
Switzerland	1981	after 2005	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	106	6%	30

N/A: information not available

Data are taken from World Health Organization's publications (5,12-16). Where data were conflicting between publications, the most recent source was used

ers are out-of-date and in need of improvement (17). What is more, although around 40% of countries with mental health legislation in place have updated their legislation or adopted new legislation since 2005, around one quarter of countries still have legislation in place that is over 10 years old (see Table 1).

RESEARCH IN THE REGION

Research evidence from systematic reviews and randomized controlled trials (RCTs) evaluating community mental health services across the region is displayed in Tables 2 and 3. Overall, this evidence suggests that, in principle, community-based mental health care is effective. There is some evidence for the effectiveness of an integration of mental health into primary health services across different models of care, as well as for community mental health teams, assertive community treatment, intensive case management, crisis intervention, and supported employment. However, high-quality evaluative evidence for other mainstream or specialized community mental health services is inconsistent or missing. In fact, for most European countries, there is a dearth of high-quality research on community-based mental health services, with most RCTs in the region having been conducted in the UK (around 80%) and a few other high-income countries. Findings may therefore not be applicable to other countries. Moreover, results may be difficult to compare across studies due to a lack of clarity about the model of care (18,19), differences between control treatments (18), or an overlap of components of community-based treatment with standard treatment (and therefore differences in outcomes being reduced) (19). Further issues are that services assessed in studies are often not sustained (19), and that there is a lack of studies assessing cost-effectiveness of services.

Other than trials of effectiveness, there have been some observational and qualitative studies conducted in Europe (mostly in the UK). These have shown that home treatment is viewed positively by service providers (44), and that specific community mental health services, such as women's crisis houses, are highly valued by service users (45). Some of the processes that may be important to the effectiveness and sustainability of community mental health services have also been identified in this way, including staff satisfaction (47), views on interdisciplinary working (46-51), and involvement of service user views (52-60).

OVERVIEW OF MENTAL HEALTH SERVICES

Generally, a wide range of community mental health services exists within Europe, with at least some available in every country. However, whilst a few countries lead the way in the successful implementation of community-based mental health services according to an evidence-based "balanced care model" that integrates elements of community and hospital services (4,61-65), in many others access to community-based services is still very limited and may commonly consist of small pilot projects (12).

Broadly speaking, consistent with economic differences across the region, the division is mostly between the Eastern and Western countries of Europe. In the EU-15 countries and other predominantly Western high income countries, following a move towards human rights, social inclusion and empowerment over the last few decades, a large array of multidisciplinary community-based services may be available to people with mental health problems, with most patients being treated outside of mental institutions (5). In line with the "balanced care model" approach, the mental hospitals that do exist in these countries are often relatively small, close to communities (12), and usually located in acute wards in general hospitals, with hospital stays reduced as far as possible (9,61).

In the low or lower-middle income non-EU countries of Eastern Europe, in particular the CIS countries, access to community-based care tends to be far more limited. Large mental health institutions are commonly still the mainstay of the mental health care system (5), and community mental health services are often restricted to polyclinics or dispensaries attached to a psychiatric office. Where any additional community-based services exist, these are often implemented by non-governmental organizations (NGOs) or international agencies. The range and quality of mental health services in the post-2004 EU countries and other middle income countries tend to lie somewhere between those of the EU-15 and CIS countries. However, the boundaries of this divide are blurry, and no two countries in the region have the exact same mental health system in place.

Inpatient services

In general, the number of psychiatric beds has been decreasing steadily across Europe and mental hospitals are increasingly being closed down (7). However, in some countries this process has been much slower than in others (9,17). Although inpatient services in mental hospitals still exist in almost all European countries (the exceptions are Italy, Iceland, Andorra, Monaco and San Marino), the number of psychiatric beds and the balance between beds in mental institutions and inpatient community-based facilities varies greatly between countries (see Table 1). Whilst in some countries the small number of inpatient beds is due to the substantial progress that has been made in replacing mental hospitals with community-based care (the UK and Italy for example), in others (such as Albania and Turkey) the small number of beds reflects a lack in funding and a deficit in service provision for mental health overall. Other countries, primarily EU-15 countries such as Belgium, France, Germany, and the Netherlands, have a combination of large numbers of inpatient beds and community services (12). However, in most European countries (in particular those in Eastern parts) institutional care still outweighs community care

Table 2 Overview of systematic reviews evaluating community mental health services in the European Region

Authors	Service evaluated	N. studies included	Main outcomes
Burns et al (18)	Community care (range of services) compared to admission	91	Benefits in terms of days hospitalized (regardless of service type) Inconclusive in terms of cost-effectiveness
Wright et al (19)	Community care (components of care related to effectiveness)	55	Regular home visiting and taking responsibility for both health and social care associated with reduced hospitalization (regardless of service type)
Harkness and Bower (20)	On-site mental health workers in primary health care (replacement model) compared to off-site mental health services	42	Small and inconsistent reduction in number of consultations with primary care providers, psychotropic prescribing, prescribing costs and rates of referral No effects on prescribing or referrals in the wider patient population Cost-benefits unclear
Gilbody et al (21)	Collaborative care compared to usual care	34	No significant predictor of antidepressant use Key predictors of depression symptom outcomes were systematic identification of patients, professional background of staff and specialist supervision
Malone et al (22)	Community mental health teams compared to non-team standard care (delivered as community, outpatient or hospital treatment)	3	Reduction in hospital admissions and number of deaths by suicide Promoted greater acceptance of treatment
Marshall et al (23)	Case canagement compared to standard community care	10	Increased number of patients remaining in contact with services Greater proportion of patients hospitalized No significant benefits on psychiatric or social variables Cost-effectiveness inconclusive
Marshall and Lockwood (24)	Assertive community treatment compared to standard community care, hospital-based rehabilitation, or case management	20	Improves outcome and patient satisfaction Reduces costs of hospital care for high users of in-patient care
Burns et al (25)	Intensive case management compared to standard care for people with serious mental disorders	29	Small but statistically significant reduction in days spent in hospital overall, but large variation between studies Largest effects when patients had high hospital use at baseline, and the more closely treatment adhered to principles of assertive community treatment Setting of trial did not have effect
Marshall and Lockwood (26)	Early intervention for psychosis	7	Evidence of poor quality overall and studies not comparable due to different intervention approaches taken
Irving et al (27)	Crisis intervention and resolution teams (delivered as part of an on-going home treatment package)	5	Reduction in admissions May be less expensive than standard care, but more data is needed to confirm this
Macpherson et al (28)	Community-based residential care (24-hour staffed) compared to standard hospital care	1	Patients more likely to use social facilities and spent more time in socially constructive facilities (such as self-care, eating with group) Study was small and of poor quality
Marshall et al (29)	Acute day hospital care compared to inpatient care	9	At least one fifth of patients admitted to inpatient care could be cared for in an acute day hospital More rapid improvement in mental state, but not social functioning Less expensive

by far, with around two thirds of all psychiatric beds across the region still located in mental hospitals (7).

Mental health in primary health care

Whilst all countries in the European Region increasingly have mental health services integrated into primary health care (see Table 1), the extent of this varies widely. In many countries the primary health care system for mental health is still inadequate (12), and even in high income countries the provision of mental health services within primary care has often been found to be less than optimal (66). Mental health training for primary care staff is only available in around two thirds of countries (12), and is often insufficient, which frequently results in mental health problems not being recognized or treatment methods being unknown (7,9).

Table 3 Overview of randomized controlled trials (RCTs) evaluating community mental health services in the European Region

Authors	Service evaluated	Country, N. subjects	Main outcomes
Richards et al (30)	Collaborative care compared to usual care	UK, 114	Reduction in symptoms for depressive patients
Killaspy et al (31,32) McCrone et al (33)	Assertive community treatment compared to usual care from a community mental health team	UK, 251	No difference in the need for in-patient care, clinical or social outcomes More contact with patients involved, but no difference in costs Increased client satisfaction and engagement with services
Morrison et al (34)	Early intervention in patients with prodromal symptoms (cognitive behaviour therapy compared to monitoring only)	UK, 60	No difference in leaving the study early or transition to psychosis
Agius et al (35)	Assertive early intervention compared to standard community mental health team	UK, 125	Range of benefits over three years, but study not fully randomized and patients were unusually engaged with services (so results should be treated with caution)
Petersen et al (36) Bertelsen et al (37)	Intensive early intervention compared to standard treatment in patients with first episode schizophrenia	Denmark, 547	Improved clinical outcome at two years, but effects not sustained at 5-year follow-up Differences in the proportion of patients living in supported housing and days in hospital in favour of early intervention at 5-year follow-up
Johnson et al (38) Cotton et al (39)	Crisis resolution team (24-hour short-term care) compared to standard care in patients who were experiencing a crisis severe enough to be eligible for admission	UK, 260	Reduction in admissions Patients most likely to be admitted to hospital were those who were uncooperative with initial assessment, were at risk of self-neglect, had history of compulsory admission, were assessed outside usual office hours and/or were assessed in hospital casualty departments Increased patient satisfaction
Priebe et al (40)	Acute day hospital care compared to conventional wards	UK, 260	Greater improvement in psychopathology at discharge, but not at follow-up Higher patient treatment satisfaction at discharge and after 3 months, but not after 12 months More expensive
Burns et al (41,42) Catty et al (43)	Vocational rehabilitation services (supported employment) compared to other high-quality vocational services	UK, Germany, Italy, Switzerland, Netherlands, Bulgaria; 312	Competitive employment obtained more often, jobs kept longer and more hours worked More unwell people helped into work Working associated with better clinical and social outcomes at 18 months Patients with previous work history, fewer met social needs and better relationships with their vocational workers were more likely to obtain employment and work for longer

Note: Where there has been a systematic review published of a particular service, only those RCTs are displayed which were conducted after the review

Community mental health services

Although there is a definite trend towards an increase in community-based mental health services and a decrease in institutional care (12), the pace and scale at which this is occurring, as well as the quality of services, varies widely throughout the region (7,17). For instance, at least 85% of countries now report having mental health day care, but in some countries such services tend to be attached to long-term mental hospitals or may be very limited in number, while in others there may be a variety of day care services available in a selection of community settings (12). Furthermore, access to such services may be very limited within countries, especially in the Eastern parts of the region (12). Variables such as location, age, gender, ethnicity, employment status, type of diagnosis, educational background or socioeconomic status may determine whether care, and what type of care, is received (7,9, 12,67,68). One example of this is that more services tend to be available in urban areas compared to rural settings.

LESSONS LEARNED AND RECOMMENDATIONS

We present here an overview of the lessons learned in the implementation of community mental health services across Europe, as well as recommendations for the region in the future. Specific steps on how to facilitate and implement these can be found in the WPA Guidance (4).

Treatment gap

Clinical experience and research evidence have shown that the implementation of community mental health services according to a "balanced care model" is possible and desirable (4,61-65). However, there is still a gap between population need and actual service provision across Europe, both between and within countries (67,68). To reduce the gap between the Eastern and Western parts of Europe and to scale up services across the region, the focus should be on the development of community-based services in the low and middle income countries, whilst sustaining and improving services in high income settings. Furthermore, equal access for all needs to be ensured *within* countries, that is across different regions and subgroups of the population (9,12). Changes in service provision should be carefully planned to ensure gradual, balanced and sustainable reform, which takes into account local conditions and resources, as well as the cultural context (61,64).

One important factor in making services accessible to whole populations is the continued integration of mental health services into primary health care, and an improvement in the quality of care within these systems. This may be facilitated by ensuring that there are sufficient numbers of primary care staff, regulating training, organizing adequate and ongoing supervision of primary care staff by mental health professionals, addressing staff attitudes, and by developing and managing coordinated support networks with specialized community mental health services and other relevant sectors (such as social welfare, health, housing and employment, as well as NGOs and the private sector) (7).

Human rights, stigma and social inclusion

The lack of adequate community mental health services in some parts of Europe may lead to the social isolation of people with mental health problems, or even a violation of their human rights through neglect and abuse (12). Even in high income countries (where community services tend to be more established), people with mental health problems may still be subject to stigma, prejudice and discrimination (7). National programmes and plans should therefore be implemented to ensure that the human rights of people with mental disorders are upheld, their social inclusion and full integration into society (including in the workplace) is encouraged, and stigma and discrimination are reduced. These may include public mental health promotion, advocacy and awareness-raising programmes, both for the general population (for instance through media campaigns) as well as for health staff and personnel in the other relevant sectors mentioned above (7,9-12). Furthermore, care services should be monitored and reviewed regularly to ensure that human rights standards are upheld (12). Importantly, the views of service users, their families and carers (as well as any other stakeholders) should be included in the planning and implementation of policies, and in service development, monitoring and provision (7,9,12,61,64). Currently, service user involvement is highest amongst EU-15 and other EU countries, but is only in the early stages of development in most Eastern European countries (12).

Legislation, policies, plans and programmes

One of the first steps in ensuring fair access to services for all is the formulation of carefully planned mental health legislation and policies that take into account a wide range of stakeholders' views (9). Even though there has been much progress in recent years, several countries in the European Region still do not have adequate mental health legislation and policies in place. Comprehensive new national policies and legislation (including mental health promotion, prevention and advocacy) should be developed where these are absent, and older existing mental health policies and legislation should be updated. This needs to consist of a commitment not just by health ministries, but also by the other sectors already mentioned which may be relevant to mental health care (7,9). To address challenges in the implementation of these policies and to reduce the gap between mental health policy and practice, in particular in some of the Eastern and South-Eastern countries of the region (12), detailed, feasible (though ambitious), sustainable and highly practical implementation plans and programmes should be developed.

Resources (financial and human)

A common challenge in implementing mental health policies is the lack of adequate funding mechanisms for mental health, in particular in much of Eastern Europe (17). Related to this is a shortage of human resources. Mental health staff numbers have increased in several EU countries (9), but most of the mental health workforce in Europe is concentrated in a few high income countries, and human resources for mental health are still lacking in many other parts of the region (12). For example, whilst some of the high income countries such as Belgium, Finland and Iceland have over 20 psychiatrists per 100,000 population, other countries such as Turkey or Tajikistan have less than 2 (see Table 1). This shortage typically results in mental institutions being retained and staff being assigned to mental institutions (7), which in turn leads to community mental health facilities being hugely understaffed (17). Moreover, mental health workers are often underskilled due to insufficient resources for training (7,12).

Since community mental health care overall has been shown to be cost-neutral compared to institutional care (61,62,64,65), one solution in optimizing the use of available resources is to gradually shift financial and human resources from large mental institutions to community services (9,61, 62,64,65). This requires a changing of staff roles, responsibilities and expertise, for instance through mental health workforce strategies (12), as well as new ongoing mental health

training programmes and an inclusion of mental health into general health care education programmes (7,9, 12,61,64). Staff anxieties and uncertainties due to changing roles and service structures should also be addressed (61,64), and working conditions and pathways for career development should be improved to reduce staff turnover (7).

Research evidence

An evidence base is vital to determine the effectiveness of community mental health services. However, this is still lacking for most countries in the European Region, in particular outside the UK and other high income (primarily EU-15) countries. High-quality and well-defined evaluative research is needed across countries to strengthen the evidence base for clinical outcomes and cost-effectiveness of community mental health services, as well as the relative effectiveness and efficiency of policies and programmes (12). To avoid duplicating information unnecessarily, this should include standardizing data collection systems and indicators across the region (for instance through the publishing of data collection guidelines) (7,9,12), and forming a consensus on definitions of service components (12). This, together with adequate dissemination systems, may enable evidence-based comparisons of services and programmes to be made, which may in turn inform policies (7,9,12) and allow for a more informed allocation of limited resources (7).

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